MDR Tracking Number: M5-04-2432-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 03-29-04.

CPT code 95851 date of service 11-18-03 was withdrawn from the dispute on 07-12-04 by Kathy Owens at Main Rehab and Diagnostics. This service will not be reviewed by the Medical Review Division.

The IRO reviewed Level III office visits, therapeutic exercises, electrical muscle stimulation, hot/cold pack therapy, muscle testing, neuromuscular re-education and Level II office visits rendered from 04-29-03 through 10-28-03 (excluding 08-18-03 and 10-21-03) that were denied based upon "U".

The IRO determined that therapeutic exercises, electrical muscle stimulation, hot/cold pack therapy, muscle testing, neuromuscular re-education **were not** medically necessary. The IRO determined that office visits 1-2 times monthly which include dates of service 04-29-03, 05-15-03, 07-11-03, 07-22-03, 08-04-03, 09-02-03, 09-23-03 and 10-06-03 **were** medically necessary. The IRO determined that all other office visits **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-07-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99213-QU date of service 08-07-03 denied with denial code "JM" (accurate coding of services rendered is essential for proper reimbursement. The code and/or modifier billed is invalid).
The QU modifier is valid per the Medicare Fee Schedule (QU-Physician providing service in an urban HPSA). Reimbursement is recommended in the amount of $72.81 ($52.95 X 125% = $66.19 plus 10% incentive of $6.62).

CPT code 99213 dates of service 08-12-03, 08-13-03, 08-14-03, 08-18-03, 08-20-03 and 10-21-03 (6 DOS) denied with denial code "D" (duplicate). The carrier did not specify what service CPT code 99213 was a duplicate to. Reimbursement per the Medical Fee Guideline effective 08-01-03 is $397.14 ($52.95 X 125% = $66.19 X 6 DOS). However, the requestor billed and disputed $61.81 for each DOS. Reimbursement is recommended in the amount of $370.86 ($61.81 X 6 DOS).

CPT code 97110-QU dates of service 08-12-03, 08-13-03, 08-14-03, 08-18-03, 08-20-03 and 10-21-03 (6 DOS) denied with denial code "D" (duplicate). The carrier did not specify what service CPT code 97110-QU was a duplicate to. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of

the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement is not recommended.

CPT code 99080-QU date of service 11-24-03 denied with denial code "N" (not appropriately documented). The requestor did not submit documentation for review. No reimbursement recommended.

CPT code 99212-QU date of service 11-25-03 denied with denial code "S" (supplemental payment). Reimbursement per the Medical Fee Guideline effective 08-01-03 is $51.96 ($37.78 X 125% = $47.23 plus 10% incentive of $4.73). However, the requestor billed $44.74. Additional reimbursement is recommended in the amount of $29.59 ($44.74 minus carrier payment of $15.15).

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 04-29-03 through 11-25-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 17th day of November 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 2, 2004

RE: AMENDED DECISION
MDR Tracking #: M5-04-2432-01
IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of

interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant is a 49-year-old female who injured her left knee and left ankle on ___ she slipped and fell on ice at the job site. The claimant initially sought care from _____ on 1/27/03 from _____ whose treatment consisted of active and passive physiotherapy modalities. The claimant had an MRI of the left knee and left ankle performed on 2/12/03 at _____. The MRI of the left knee revealed moderate joint effusion, mildly marked chondromalacia in the posterior patella and myxoid degeneration of the medial and lateral meniscus. The MRI of the left ankle revealed possible tenosynovitis of the hallucis longus tendon and dorsal talanavicular ligament with joint effusion. The claimant had an orthopedic evaluation performed on 3/7/03 with _____ and recommended diagnostic arthroscopy of the left knee, which was performed on 4/8/03 and revealed grade IV chondromalacia of the patella and grade IV chondromalacia of the medial femoral condyle. The claimant has received a series of Hyalgan injection from _____. It does appear that the claimant has participated in an extensive rehabilitation program at _____ for approximately 37 office visits from 4/29/03-11/25/03.

Requested Service(s)

Level III Office visits, therapeutic exercises, electrical muscle stimulation, hot/cold pack therapy, muscle testing, neuromuscular re-education and Level II office visits for dates of service 4/29/03-10/28/03, excluding 8/18/03 and 10/21/03

Decision

I agree with the insurance carrier that therapeutic exercises, electrical muscle stimulation, hot/cold pack therapy, muscle testing, neuromuscular re-education are not reasonable and necessary for the dates in dispute.

I disagree with the insurance carrier and find that office visits are reasonable and necessary for 1-2 times monthly. In referring to the Table of Disputed Services, the following office visits are considered to be medically necessary:

4/29/03, 5/15/03, 7/11/03, 7/22/03, 8/4/03, 9/2/03, 9/23/03, 10/6/03

I agree with the insurance carrier that all other office visits, not on the dates listed above, are not medically necessary.

Rationale/Basis for Decision

The claimant apparently has a degenerative condition in the left knee, which was exacerbated by the compensable event. The claimant has grade IV chondromalacia of the left knee, which failed to respond to extensive conservative treatment/rehabilitation, arthroscopic procedure and

Hyalgan injections. The claimant is a candidate for total knee replacement and due to the claimant poor response to conservative rehabilitation the claimant should be released from conservative care at MMI with maximum therapeutic benefit. The Official Disability Guidelines allows 9 physiotherapy visits over a 8-week period for the diagnosis of chondromalacia of the patella. The claimant should fade from treatment/rehabilitation and be directed with a home therapy program to treat the affected region. Therefore, the use of therapeutic exercises, neuromuscular re-education, electrical muscle stimulation are not reasonable and necessary for the dates in dispute. I reference the Occupational Medicine Practice Guidelines second edition, page 48, " During the acute and subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as the application of heat and ice for temporary amelioration of symptoms and to facilitate mobilization and graded exercises. They are most effective when the patient uses them at home several times a day. Although not for long-term use, transcutaneous galvanic and electrical stimulation can keep symptoms at bay temporary, diminishing pain long enough so that the patient can begin mobilization. Little evidence exists for the effectiveness of other passive modalities." Therefore the use of hot/cold pack therapy and electrical muscle stimulation is not reasonable and necessary for the dates in dispute.

It does appear that _____ is the treating physician for the claimant. These office visits should be allowed 1-2 times monthly during the dates in dispute to determine the claimant's progress with home treatment or to make the appropriate referrals.